

01026

## CERTIFICATE OF DEATH

01025

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>DISTRICT OF COLUMBIA</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>2319 MINNESOTA AVE. S.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES M. RANDEL</u>		4. DATE OF DEATH Month Day Year <u>JAN. 10 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/88</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANICAL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-03-7989</u>	
17. INFORMANT <u>GEORGE W. RANDEL</u>		Address <u>2001 AUSTIN LANE SILVER SPRING MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>thrombosis of coronary artery</u> DUE TO (c) <u>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>66</u> , to <u>1/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u>		22b. DATE SIGNED <u>1/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u>		22d. ADDRESS <u>911 Silver Spring Ave Silver Spring MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MD.</u>
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., INC.</u>		25a. REC'D BY REGISTRAR <u>511 11th St. S.E. WASHINGTON</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED 10 11 1964

01080

RECEIVED 10 11 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					01026				
01031									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clney, M					c. LENGTH OF STAY IN 1b 10.2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					d. STREET ADDRESS MARYLAND				
3. NAME OF DECEASED (Type or print) First Middle Last Waitee Bruce Randolph					4. DATE OF DEATH Month Day Year JAN 14 1967				
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14 1961		9. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Sander		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Clarksburg Md		12. CITIZEN OF WHAT COUNTRY? C.S.			
13. FATHER'S NAME John Robert Randolph					14. MOTHER'S MAIDEN NAME DORA ELIZABETH HACKETT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 213-121954				
17. INFORMANT Mr. Arthur Randolph - Brother					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ethylism 322.0 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED JAN 14 1967									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reed M.D. Address (Street, city, town, or county) Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF Jan 20, 1967		23c. NAME OF CEMETERY OR CREMATORY John Wesley Cem.		23d. LOCATION (City, town or county) (State) Clarksburg, Md.		
24. FUNERAL DIRECTOR Robert L. Surden					25a. REC'D BY REGISTRAR DATE JAN 23 1967				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13 Film G305 1/24/67 mh

01027

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01027

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>8304 Roanoke Ave. apt. 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK NMN RAY</b>				4. DATE OF DEATH Month Day Year <b>1- 14 19 67</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-26-10</b>	
9. AGE (In years last birthday) <b>56</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Unknown Ray</b>				14. MOTHER'S MAIDEN NAME <b>Mary B. - <del>Bennett</del> Jenkins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Willie Mae Ray</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO (b) <b>Coronary Artery Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL-CREATION, REMOVAL (Specify) <b>Jan. 18-1967</b>				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery, Suitcase</b>				23d. LOCATION (City or Town) (County) (State) <b>JAN. 14, 1967</b>			
24. FUNERAL DIRECTOR <b>Arthur Walters</b>				25a. RECD BY REGISTRAR DATE <b>JAN 17 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

01037

01037

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01028

## CERTIFICATE OF DEATH

01028

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>2 YRS - 2 MO</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>11608 LOCKWOOD DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EVELYN</b>		First		Middle <b>HOUSE</b>		Last <b>REED</b>		4. DATE OF DEATH <b>1-26</b>		Month		Day		Year <b>1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-1882</b>		9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>AUSTIN, TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Carter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gorsich</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Helen Royston</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronal thrombosis</b> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronal Arteriosclerosis</b> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 1964, to <b>1-26</b> , 1967, that (I) (we) last saw the deceased alive on <b>12-14</b> 1966, and that death occurred at <b>1 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Morton Altschuler</b>		22b. DATE SIGNED <b>1/26/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Morton Altschuler, MD</b>		22d. ADDRESS <b>5205 New Hampshire Ave Silver Spring</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>Jan 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Mausoleum</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges Co., Maryland</b>		24. FUNERAL DIRECTOR <b>Clark &amp; Wisor</b>	
25a. REC'D BY REGISTRAR <b>Jan 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Warner E. Humphrey, Inc.</b>		25d. REGISTRAR'S ADDRESS <b>434 Georgia Avenue Silver Spring, Md.</b>		25e. REGISTRAR'S PHONE <b>434</b>		25f. REGISTRAR'S TELETYPE <b>434</b>		25g. REGISTRAR'S FAX <b>434</b>		25h. REGISTRAR'S E-MAIL <b>434</b>		25i. REGISTRAR'S OTHER <b>434</b>	

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Handwritten text on the right margin, possibly a signature or date.

# FOR STATE HEALTH DEPT.

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Items 18&21 Film 387 3-23 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 8,9 Film G385 1/24/67 mb

01029

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01029

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb. <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp.</u>		d. STREET ADDRESS <u>11010 West ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY BANKS REED</u>		4. DATE OF DEATH <u>JAN. 13 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Banks</u>		14. MOTHER'S MAIDEN NAME <u>Mary Crawford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>061-26-4156</u>	
17. INFORMANT <u>Son</u>		<u>12509 Denley Rd. Wheaton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5870</u> IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatitis</u> DUE TO (b) <u>accompanied by Arteriosclerotic heart</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>JAN. 13, 1967</u>	
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-16-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Goshen Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Goshen, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 18 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



01033

01033

# FOR STATE HEALTH DEPT.

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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01030

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01030

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>D. O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH. SAN. &amp; HOSP.</b>				d. STREET ADDRESS <b>12201 VILLAGE SQUARE TERR</b>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>(AKA-)</b> Last <b>REMIG</b>				4. DATE OF DEATH Month <b>1</b> Day <b>-26</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 16, 1913</b>		9. AGE (In years lost birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>26</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Remig</b>				14. MOTHER'S MAIDEN NAME <b>May A. Snyder</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Virginia Hyble</b> Address <b>1430 Rhode Island Ave. N.W. Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5810</b> IMMEDIATE CAUSE (a) <b>Severe, Fatty Metamorphosis of Liver.</b> DUE TO (b) <b>of Liver.</b> DUE TO (c) <b>of Liver.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>1-27-1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Passaic, New Jersey</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Passaic, New Jersey</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
Warner & Humphrey, Inc.		Silver Spring, Md.		DATE <b>FEB 1 1967</b>			

01030

01030

RECEIVED

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01032

CERTIFICATE OF DEATH

01031

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>700 Taney Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Addie Elizabeth Rhodes</b>		4. DATE OF DEATH <b>January 27 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/14/92</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Reeves</b>		14. MOTHER'S MAIDEN NAME <b>Addie Boring</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5705</b> IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> DUE TO (b) <b>Abdominal adhesions</b> DUE TO (c) <b>Previous abdominal Surgery</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/24 5:2</b> , to <b>1/27 67</b> , that (I) (we) lost saw the deceased alive on <b>1/27 1967</b> , and that death occurred at <b>7:30 PM</b> , from causes on and on the date noted above.			
22a. SIGNATURE <b>Charles H. Ligon</b>		22b. DATE SIGNED <b>1/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Ligon, M.D.</b>		22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 1, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reeves Family Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Johnson City, Tenn</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01031

STATE OF TEXAS

01031

County of Tarrant, Texas, ss. I, the undersigned, Judge of the County Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County Court.

Witness my hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Attest:

My hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Notary Public for Texas.

My commission expires the 1st day of January, 1904.

Witness my hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Attest:

My hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Notary Public for Texas.

My commission expires the 1st day of January, 1904.

Witness my hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Attest:

My hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Notary Public for Texas.

My commission expires the 1st day of January, 1904.

Witness my hand and the seal of said County Court at Fort Worth, Texas, this 1st day of January, 1903.

Attest:



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

BP

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01033					CERTIFICATE OF DEATH			01032			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>			16.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hosp.</u>					d. STREET ADDRESS <u>Box 459-Lottsford Rd</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Edwin</u> Last <u>Rice, Sr.</u>					4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-16</u>		9. AGE (In years lost birthday) yrs. <u>50</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Employed-Co.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>John Rice</u>					14. MOTHER'S MAIDEN NAME <u>Ellen Louise Graham</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Edna E. Rice</u> Address <u>Same as Item #2.</u> <u>Hospital Records</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, TAIL OF PANCREAS WITH METASTAS</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }										INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>a.m.</u> Month <u>19</u> Day <u>19</u> Year <u>1967</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (H) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>66</u> , to <u>1/11</u> , 19 <u>67</u> , that (H) (we) last saw the deceased alive on <u>1/11</u> , 19 <u>67</u> , and that death occurred at <u>11</u> A.M., from causes and on the date stated above.											
22a. SIGNATURE <u>Seruch T. Kimble</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>1-11-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble, M.D.</u>					22d. ADDRESS <u>927 Pershing Drive, Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Maryland</u>				
24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

Rivonia House, Upper Marlboro, Md.

Partial 1/1/57

Wm. Lincoln Cemetery, Hinghamburg,

Section 1, Block 1, N.W.

211 1st St., Silver Spring, Md.

John Rice

Male White

Employed - 10 years  
Special Agent

Pennsylvania

N.S.P.

211 1st St., Silver Spring, Md.

Hospital Records  
211 1st St., Silver Spring, Md.

Washington San. Hosp.  
Takoma Park 11 days

Donald X Edman

Rice, Jr.

January 11 57

4-19-16

Box 457 - Lancaster Rd

Landon

Montgomery

Hartford

01957

01957

01034

## CERTIFICATE OF DEATH

01033

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington - D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington -</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 6 mo 3 ds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>		47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>3603 - 24th St. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>J.</u> Last <u>Rich</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April-3-1899</u>		9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bristol - Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Anthony Rich</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Martin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>578-01-8193</u>		17. INFORMANT <u>Paul Rich - 11422 Cedar Lane,</u>		Address <u>Belt St. N.E., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Sen and Coronary atherosclerosis</u> DUE TO <u>years</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Parkinsonism - years - delirium</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>Jan 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 22, 1967</u> , and that death occurred at <u>12:05</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas E. Curtin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS E. CURTIN</u>				22d. ADDRESS <u>4600 Connecticut Ave. N.W. Wash D.C.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 31, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) <u>VA</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Attoruel</u>				ADDRESS <u>3603 14th St. N.W. Wash D.C. 20004</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 31 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

0303

03034

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G385 1/26/67 mh

01036

## CERTIFICATE OF DEATH

01034

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington D.C.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>14 hrs - 25 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>4116 EMERY PLACE N.W.</u>		
3. NAME OF DECEASED (Type or print) <u>LAWRENCE ERNEST</u> <u>Richards</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/88</u> 1890	9. AGE (in years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interim Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>James Richards</u>			14. MOTHER'S MAIDEN NAME <u>(Unknown) Watkins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOCIAL SECURITY NO. <u>578 52 6436</u>		17. INFORMANT <u>Mary E. Richards - wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u> DUE TO <u>Cerebro-Vascular arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 years</u> (c) <u>2 days</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral pneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1967</u> to <u>January 1967</u> , that (I) (we) last saw the deceased alive on <u>February 1967</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Joseph Kuntz</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>1-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Joseph Kuntz M.D.</u>					22d. ADDRESS <u>301 Connecticut Ave. N.W.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01035

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01035

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairfairsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>R.F.D. #1</u>			
3. NAME OF DECEASED (Type or print) <u>Grace Fuzita Richardson</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1916</u>	9. AGE (In years last birthday) yrs. <u>50</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Lester Park</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wessells</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>  </u>				17. INFORMANT <u>Mont B. Richardson</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year 5.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John W. Ball</u> M.D.				22. DATE SIGNED <u>1/8/67</u>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-11-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash. DC.				DATE <u>JAN 12 1967</u>			

01088

01088

01037

## CERTIFICATE OF DEATH

Reg. Dist. No.

01036

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>				d. STREET ADDRESS <u>16021 Georgia Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Zephyr</u> Middle <u>none</u> Last <u>Ricks</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884</u>		9. AGE (In years last birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months <u>15</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Monroe Ricks</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-05-4634</u>		17. INFORMANT <u>records of</u> Address <u>Montgomery General Hospital, Olney, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>610X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Prostatic Hypertrophy</u> DUE TO (c) <u>And Nephrosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric ulcer</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-60</u> to <u>1-14</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>1-14</u> , 19 <u>67</u> , and that death occurred at <u>11: P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Olney, Maryland</u> DATE SIGNED <u>1-15-67</u>							
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Richard A. Yates, M.D.</u>				<u>Olney, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/20/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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JAN 10 1964		JAN 10 1964	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
WASHINGTON, D.C. 20535		WASHINGTON, D.C. 20535	
1. NAME OF SUBJECT		2. DATE OF BIRTH	
3. SEX		4. RACE	
5. HEIGHT		6. WEIGHT	
7. EYES		8. HAIR	
9. COMPLEXION		10. BLOOD TYPE	
11. SOCIAL SECURITY NUMBER		12. MARITAL STATUS	
13. OCCUPATION		14. EDUCATION	
15. PRESENT ADDRESS		16. PREVIOUS ADDRESSES	
17. DATE OF ENTRY INTO COUNTRY		18. DATE OF DEPARTURE FROM COUNTRY	
19. REASON FOR ENTRY		20. REASON FOR DEPARTURE	
21. CURRENT EMPLOYER		22. EMPLOYMENT HISTORY	
23. TRAVEL HISTORY		24. FOREIGN TRAVEL	
25. FOREIGN RESIDENCE		26. FOREIGN EMPLOYMENT	
27. FOREIGN CITIZENSHIP		28. FOREIGN MARRIAGE	
29. FOREIGN CHILDREN		30. FOREIGN DEATHS	
31. FOREIGN CRIMINAL RECORD		32. FOREIGN CIVIL RECORD	
33. FOREIGN FINANCIAL RECORD		34. FOREIGN EDUCATIONAL RECORD	
35. FOREIGN MEDICAL RECORD		36. FOREIGN PSYCHOLOGICAL RECORD	
37. FOREIGN LEGAL RECORD		38. FOREIGN POLITICAL RECORD	
39. FOREIGN RELIGIOUS RECORD		40. FOREIGN SOCIAL RECORD	
41. FOREIGN CULTURAL RECORD		42. FOREIGN ARTISTIC RECORD	
43. FOREIGN SCIENTIFIC RECORD		44. FOREIGN LITERARY RECORD	
45. FOREIGN SPORTS RECORD		46. FOREIGN MUSIC RECORD	
47. FOREIGN THEATRE RECORD		48. FOREIGN FILM RECORD	
49. FOREIGN TELEVISION RECORD		50. FOREIGN RADIO RECORD	
51. FOREIGN PRESS RECORD		52. FOREIGN PUBLICATION RECORD	
53. FOREIGN PATENT RECORD		54. FOREIGN TRADE RECORD	
55. FOREIGN INVESTMENT RECORD		56. FOREIGN BANKING RECORD	
57. FOREIGN TAX RECORD		58. FOREIGN INSURANCE RECORD	
59. FOREIGN VEHICLE RECORD		60. FOREIGN AIRCRAFT RECORD	
61. FOREIGN SHIP RECORD		62. FOREIGN SPACE RECORD	
63. FOREIGN NUCLEAR RECORD		64. FOREIGN BIOLOGICAL RECORD	
65. FOREIGN CHEMICAL RECORD		66. FOREIGN PHYSICAL RECORD	
67. FOREIGN MEDICAL RECORD		68. FOREIGN PSYCHOLOGICAL RECORD	
69. FOREIGN LEGAL RECORD		70. FOREIGN POLITICAL RECORD	
71. FOREIGN RELIGIOUS RECORD		72. FOREIGN SOCIAL RECORD	
73. FOREIGN CULTURAL RECORD		74. FOREIGN ARTISTIC RECORD	
75. FOREIGN SCIENTIFIC RECORD		76. FOREIGN LITERARY RECORD	
77. FOREIGN SPORTS RECORD		78. FOREIGN MUSIC RECORD	
79. FOREIGN THEATRE RECORD		80. FOREIGN FILM RECORD	
81. FOREIGN TELEVISION RECORD		82. FOREIGN RADIO RECORD	
83. FOREIGN PRESS RECORD		84. FOREIGN PUBLICATION RECORD	
85. FOREIGN PATENT RECORD		86. FOREIGN TRADE RECORD	
87. FOREIGN INVESTMENT RECORD		88. FOREIGN BANKING RECORD	
89. FOREIGN TAX RECORD		90. FOREIGN INSURANCE RECORD	
91. FOREIGN VEHICLE RECORD		92. FOREIGN AIRCRAFT RECORD	
93. FOREIGN SHIP RECORD		94. FOREIGN SPACE RECORD	
95. FOREIGN NUCLEAR RECORD		96. FOREIGN BIOLOGICAL RECORD	
97. FOREIGN CHEMICAL RECORD		98. FOREIGN PHYSICAL RECORD	
99. FOREIGN MEDICAL RECORD		100. FOREIGN PSYCHOLOGICAL RECORD	



01038

## CERTIFICATE OF DEATH

01037

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>62 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jacksonville</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>3950 Aldington Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Roy Edward Ripley</b>		4. DATE OF DEATH Month <b>January</b> 25 19 <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 April 1912</b>
9. AGE (In years lost birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Lake City, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Ripley</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Gray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>483 48 3456</b>	
17. INFORMANT <b>Wife, Mrs Elsie Ripley Jacksonville, Fla.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>Squamous cell carcinoma nasopharynx with diffuse metastases to bone marrow.</b>	
19. INTERVAL BETWEEN ONSET AND DEATH		20. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>146X</b> DUE TO (b) DUE TO (c)	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	26a. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	27a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	28a. (City or town) (County) (State)
29. I certify that (I) <del>intended</del> attended the deceased from <b>24 NOV</b> , 19 <b>66</b> , to <b>25 JAN</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>25 JAN</b> , 19 <b>67</b> , and that death occurred at <b>800a</b> am, from causes and on the date stated above.			
30a. SIGNATURE <i>Elliot Perlin</i> M.D.		31. DATE SIGNED <b>27 JAN 1967</b>	
32a. PHYSICIAN'S NAME (Type) <b>ELLIOT PERLIN</b>		33. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD</b>	
34a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	35a. DATE THEREOF <b>1-30-67</b>	36a. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEMETARY</b>	37a. LOCATION (City or Town) (County) (State) <b>ARLINGTON, FAIRFAX, VIRGINIA</b>
38. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		39. ADDRESS <b>7557 WISCONSIN AVE, BETHESDA</b>	
40. REC'D BY REGISTRAR <b>DATE FEB 2 1967</b>		41. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01039

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01038

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>-</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>23hr. 40min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4216-37th. St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maxwell E. Roberts</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-87</u>	9. AGE (In years of birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Lumber Self-Employed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Biles Roberts</u>			14. MOTHER'S MAIDEN NAME <u>Jane Hayes</u>				
15. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Son-LEE Roberts - Kensington, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia and pulmonary edema</u> 322.1 DUE TO (b) <u>Acute + Chronic Alcoholism -</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture, left ankle (24 hours)</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at home - causing compound fracture of left ankle.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>1/16</u> 19 <u>67</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington DC</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u>				22. DATE SIGNED <u>1/18/67</u>			
EXAMINER'S NAME (Type) <u>John B. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>4302 Edgefield Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-21-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Jos. Gowler's Sons Wash. D.C.</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			

01038

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01039

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herndon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Blockwood Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Nancy</u> First <u>Robertson</u> Middle <u>Robertson</u> Last <u>Robertson</u>		4. DATE OF DEATH <u>Jan 22 1967</u> Month <u>Jan</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/1945</u> 9. AGE (In years last birthday) <u>21</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin W. Poole</u>		14. MOTHER'S M maiden NAME <u>Edna V. Poole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-44-5106</u>	
17. INFORMANT <u>Matthew - Same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage, lt. temporal lobe</u> DUE TO <u>7547</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to congenital aneurysm</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Bell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John E. Bell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/23/67</u>	
		Address (Street, city, town, or county)	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Jan 25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City or Town) (County) (State) <u>Fairbury Montgomery Md</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS <u>Fairbury Md</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01033

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1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01041

CERTIFICATE OF DEATH

01040

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>8303 Hartford Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Howard Robertson</b>		4. DATE OF DEATH <b>January 13 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-09</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Dept Contractor Bldg.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>James Robertson</b>		14. MOTHER'S MAIDEN NAME <b>Ida Creed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>578-20-0395</b>	
17. INFORMANT <b>Ruth L. Robertson</b>		18. ADDRESS <b>8303 Hartford Avenue Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: <b>490X</b> IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-21, 1966</b> to <b>1-13, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-12, 1967</b> , and that death occurred at <b>2:25</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Wolcott</b>		22b. DATE SIGNED <b>1/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Wolcott</b>		22d. ADDRESS <b>831 W. Blair St. C</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 16, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Hyattsville Md.</b>	
23e. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		23f. ADDRESS <b>4434 Georgia Avenue Silver Spring, Md.</b>	
24a. REC'D BY REGISTRAR <b>Charles Judge</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JAN 17 1967</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01042

## CERTIFICATE OF DEATH

01041

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN Tb <b>61 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			<b>151</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>7103 Fairfax Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>Carter</b> Last <b>ROBINSON</b>			4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>19 67</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 13, 1897</b>		9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hopkinsville, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Henry Carter</b>				14. MOTHER'S MAIDEN NAME <b>Mildred V. Whitaker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Lane, Chevy Chase Md.</b> <b>Mrs. Frances C. Hazelwood, 5104 Fairglen</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>EXTENSIVE METASTASES</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CANCER RIGHT BREAST</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 18</b> , 19 <b>66</b> , to <b>Jan. 19</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 19</b> , 19 <b>67</b> , and that death occurred at <b>145P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>William R Hix</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>20 JAN 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William R HIX LT MC USN</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b> <b>7557 Wisconsin, Bethesda, Md.</b>				25a. REG'D BY REGISTRAR DATE <b>JAN 30 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Naval Hospital, Bethesda, Md.

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FOR STATE HEALTH DEPT.

01043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Hilltop Rd</u>				d. STREET ADDRESS <u>101 Hilltop Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Paul</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-29</u> 37 yrs.		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor's Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry T. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Opal L. Dadsousman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-42-3084</u>		17. INFORMANT <u>Opal L. Robinson</u>		Address <u>Elkins, W. Virginia</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral laceration and</u> DUE TO (b) <u>hemorrhage due to Gunshot</u> DUE TO (c) <u>wound through head</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Deceased shot through head</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:35</u> <u>p.m.</u> <u>1-25</u> <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring</u> <u>Montg</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S SIGNATURE <u>Belden R. Reap</u>		M.D. <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>JAN, 25, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		ADDRESS <u>1331 Rock. Pike, Rockville,</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, Town, or county) <u>1331 Rock. Pike, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Belington Fraternal</u>		23d. LOCATION (City or Town) (County) (State) <u>Belington, West Va.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>				25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01044

## CERTIFICATE OF DEATH

01043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>21 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens SAN.</u>		d. STREET ADDRESS <u>7301 Birch Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Halsey</u> Middle <u>R.</u> Last <u>Rogers</u>		4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	9. AGE (In years lost birthday) <u>84</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Lariby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>518-48-2044A</u>	
17. INFORMANT <u>Mrs. Maude V. Rogers</u>		Address <u>7301 Birch Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>1-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>194</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Paul D. Cantor</u>		22b. DATE SIGNED <u>1/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL D. CANTOR</u>		22d. ADDRESS <u>4709 Montgomery Lane Bethesda Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City or Town) (County) (State) <u>Rock - D.C.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
26. ADDRESS <u>254 Carroll St. NW Washington D.C.</u>		DATE <u>JAN 11 1967</u>	

010010

RECEIVED OF DEATH

010010

NAME		LAST		FIRST		MIDDLE	
AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
MARITAL STATUS		SPOUSE NAME		SPOUSE DATE OF BIRTH		SPOUSE PLACE OF BIRTH	
FAMILY HISTORY		PARENTS NAME		PARENTS DATE OF BIRTH		PARENTS PLACE OF BIRTH	
MEDICAL HISTORY		PREVIOUS ILLNESSES		SURGERIES		HOSPITAL ADMISSIONS	
SOCIAL HISTORY		SMOKING		ALCOHOL		DRUGS	
PSYCHOLOGICAL HISTORY		MENTAL ILLNESSES		TREATMENT		HOSPITAL ADMISSIONS	
LEGAL HISTORY		CRIMINAL RECORD		CIVIL RECORD		MILITARY RECORD	
OTHER INFORMATION		FAMILY CONTACT		FAMILY ADDRESS		FAMILY PHONE	
SIGNATURE		DATE		PLACE		STATE	

RECEIVED OF DEATH

01045

## CERTIFICATE OF DEATH

01044

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Perry</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry</u> 53.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>1106 Willis Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>W.</u> Last <u>Rowles</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>94</u> yrs. <u>8-12-84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>	
13. FATHER'S NAME <u>James A. Rowles</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW 1</u>		17. INFORMANT <u>Mrs Mildred Rowles- Item # 2</u>	
16. SOCIAL SECURITY NO. <u>480-36-7655</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> , to <u>1-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-30</u> 19 <u>67</u> , and that death occurred at <u>8:40 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Stanley W. Kirstein</u>		22b. DATE SIGNED <u>1-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley W. Kirstein M.D.</u>		22d. ADDRESS <u>5140 Conn. Ave NW - DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	23b. DATE THEREOF <u>2/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Violet Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Perry, Iowa</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>Pike</u> DATE <u>FEB 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01010

01010



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01046						01045					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN ID <u>23 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>2392 GLENMOUNT CIE</u>					
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>Anna</u> Last <u>ROUCHARD</u>						4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 31, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRANCE</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lucian Adam</u>						14. MOTHER'S MAIDEN NAME <u>Marguerite Fouquet</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>075-07-2175-B</u>		17. INFORMANT <u>Mrs. Charles VanAlbert</u>				Address <u>12620 Springlock Ct. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>586x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peritonitis - Pleuritis</u> DUE TO (c) <u>Status Post cholecystectomy Cholelithotomy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Stress Ulcers multiple</u>										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>4 days</u> <u>3 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>66</u> , to <u>1-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-22</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John P. Haberlin</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-23-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John P. Haberlin</u>						22d. ADDRESS <u>1015 Spring Street, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>				23b. DATE THEREOF <u>Jan 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Le Vigan Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Haute Vienne 87, France</u>	
24. FUNERAL DIRECTOR <u>John S. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JAN 26 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

01010

01010

23 days

1981, 12 31

1981, 12 31

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

01047

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01046

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i> c. LENGTH OF STAY IN 1b <i>5 weeks</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>HOLY CROSS HOSPITAL</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>WHEATON, MARYLAND</i> d. STREET ADDRESS <i>2317 BLUE RIDGE AVE.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>HERBERT</i> Middle <i>Erskine</i> Last <i>RYAN</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>9</i> Year <i>1967</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/14/1892</i>	9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Guide</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sight Seeing Tour</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Whitehall, New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Gordon Ryan</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>M. Geneva Ryan</i> Address: <i>2317 Blue Ridge Ave. Wheaton, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>1/20/1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Right Bundle Branch Heart Block</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 1, 1967</i> to <i>1-9, 1967</i> , that (I) (we) last saw the deceased alive on <i>1-8, 1967</i> , and that death occurred at <i>1:35 PM</i> , from the causes and on the date stated above.						
22a. SIGNATURE <i>Belden R. Reap</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-9-1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		22d. ADDRESS <i>Wheaton, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 12, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Prince Georges Co., Md.</i>
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>4454 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE

Right Honble James Mackintosh

1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01048

01047

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>16 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10128 GREENOCK ROAD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>15.1</u> d. STREET ADDRESS <u>10128 GREENOCK ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM CARNEY RYAN</u>		4. DATE OF DEATH Month Day Year <u>1-25 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-04</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1-YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F.B.I. AGENT RETIRED U.S. GOVT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS G. RYAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY CARNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-40-6623</u>	
17. INFORMANT <u>Mrs Lee J. Ryan</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>1946</u> to <u>1/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>67</u> , and that death occurred at <u>12 A</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R. C. Kirchner</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R. C. KIRCHNER</u>		22d. ADDRESS <u>6480 N.H. Ave TAKOMA PARK Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Bellin</u> ADDRESS <u>3821-14th St NW Wash. DC</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> DATE <u>JAN 26 1967</u>	

01047

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01049

## CERTIFICATE OF DEATH

01048

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>TR. Geor</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>5096 Livingston Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ann</b> Last <b>SANFORD</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1886</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Albany, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Kernan</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Moore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-65-8858</b>	
17. INFORMANT <b>Doris S. Davis</b>		Address <b>5096 Livingston Terrace, Oxon Hill, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Large bowel obstruction with massive peritonitis and left strangulated incarcerated femoral hernia</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>12 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 2, 1967</b> , to <b>January 2, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 2, 1967</b> , and that death occurred at <b>6:10A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>T. D. Blanton</b>		22b. DATE SIGNED <b>3 JANUARY 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. D. BLANTON, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>JAN. 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co, 517 11th St. S. E. Wash, D. C.</b>		25a. REC'D BY REGISTRAR <b>JAN 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The) please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01050

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01049

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN ID <b>Rockville</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>13200 Okinawa Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>13200 Okinawa Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First <b>F.</b> Middle <b>SAVAGE</b> Last		4. DATE OF DEATH <b>January 20 19 67</b> Month <b>January</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 15, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Catherine McGowan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Margaret T. Graham Item # 2</b>	
17. INFORMANT <b>Margaret T. Graham Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b> <b>years.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		22. DATE SIGNED <b>1/20/67</b>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b> ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>23 1967</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01093

01090

Coronary Artery Disease  
Years

John A. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01051

01050

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 CEDAR HAVEN Rest Home Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> <u>15.1</u> d. STREET ADDRESS <u>8608 Flower Av.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>CHARLES J. SCHECK</u>		4. DATE OF DEATH <u>JAN 18 1967</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUL 9, 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New York N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>ARTHUR SCHECK</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE ACKERMAN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>084-10-9675A</u>				17. INFORMANT <u>ELIZABETH MARTELL</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia - Blood loss</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Car accident</u>															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>66</u> , to <u>1/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/18/67</u> , 19 <u>67</u> , and that death occurred at <u>8:20</u> P.M., from the causes and on the date stated above.																			
22a. SIGNATURE <u>Raymond O. West</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>				22d. ADDRESS <u>831 UNIV. BLVD E. S.I. Spand</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>1/19/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>				23d. LOCATION (City, town or county) (State) <u>BLADENSBURG, MD.</u>							
24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>				ADDRESS <u>1400 Chapin St. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE							

01051

CONTRACT OF SALE

01050

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

01052

## CERTIFICATE OF DEATH

01051

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sant Hospital</u>		d. STREET ADDRESS <u>819 Somerset Place</u>	
3. NAME OF DECEASED (Type or print) <u>Lula Catherine Schreyer</u>		4. DATE OF DEATH <u>January 12 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 21, 1892</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>No. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Grant Lee</u>		14. MOTHER'S MAIDEN NAME <u>Amelia McLamb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Mrs. Ida Woodard Lowry</u>		Address <u>Chillum, Md. 819 Somerset Pl.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Artery Thrombosis with Myocardial Infarct</u> DUE TO (b) <u>Coronary Artery Sclerosis</u> DUE TO (c) <u>5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1955</u> , to <u>January 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 16, 1966</u> , and that death occurred at <u>4 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Thomas S. Sappington</u>		22b. DATE SIGNED <u>January 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>		22d. ADDRESS <u>2233 WISCONSIN AVE., N.W., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>16 JAN. 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME</u>		ADDRESS <u>7400 GEORGIA AVE., N.W.</u>	
25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01051

STATE OF TEXAS

01052

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS  
I, the undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Court.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01052

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>15.1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELEN</b>		Middle <b>NMN</b>		Last <b>SERKEDAKIS</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH <b>1/25/67</b>		9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Demetrio Economou</b>		14. MOTHER'S MAIDEN NAME <b>Evangeline Nihtariou</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>416 Miss. Ave. Md.</b> <b>Mrs. Aspasia Asvestas Silver Spring</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Reap</b>		M.D. <b>BELDEN R. REAP M.D.</b>		22. DATE SIGNED <b>JAN. 25, 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP</b>		DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
23b. DATE THEREOF <b>1/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>SHAINES Co.</b>		ADDRESS <b>2901 14th St NW DC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

01052

01052

THE UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
JAN 27 1967  
MEMORANDUM FOR THE ATTORNEY GENERAL  
SUBJECT: [Illegible]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
01054					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					01053				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakome Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>99 Wash San &amp; Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15.1</u> d. STREET ADDRESS <u>207 Leighton Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Katherine M. Shafer</u>					4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>19 67</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17-13 53</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sect.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>				11. BIRTHPLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		
13. FATHER'S NAME <u>Edwin Shafer</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Wagner</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-30-4515</u>		17. INFORMANT <u>Sister - Esther Shafer</u> Address <u>(apartment)</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>782.4</u> IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure, cause</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>undetermined</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>														
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Washington, D. C.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>								
24. FUNERAL DIRECTOR <u>John Thomas Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

01023

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01023

B.O.A.

210-30-41

X

X

X

X

JAN. 10 1967

X

Jan. 10, 1967 (see below)

Jan. 10, 1967

Jan. 10, 1967 (see below)

Jan. 10, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Certification  
Cleared by Dr. Reed

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01055					01054				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <i>Montgomery</i>					a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
<i>Silver Spring</i>					<i>Silver Spring</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
<i>Holy Cross Hospital</i>					<i>1812 Kemberly Road</i>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <i>Orville</i> Middle <i>Alton</i> Last <i>Shepherd</i>					Month <i>January</i> Day <i>11</i> Year <i>1967</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 27, 1894</i>		9. AGE (In years last birthday) <i>72</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<i>Ret. Contractor</i>		<i>Road Paving</i>		<i>Washington, D. C.</i>			<i>U. S. A.</i>		
13. FATHER'S NAME <i>Aaron Shepherd</i>					14. MOTHER'S MAIDEN NAME <i>Irene</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>587-07-0974A</i>				
17. INFORMANT <i>Orville E. Shepherd</i>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Emphysema</i> 527.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Decompensation</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <i>8 mo.</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> to <i>Jan 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>10 Jan 1967</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>William D. And</i>					22b. DATE SIGNED <i>1/11/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>William D. And</i>					22d. ADDRESS <i>9006 Colesville Rd., S. S., Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Jan. 14, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i>					25a. REC'D BY REGISTRAR <i>AN 16 1967</i>				
<i>Warner E. Humphrey, Inc.</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

1885

1885

Washington

Washington

Washington

1813 Kentucky Road

1813 Kentucky Road

March 2, 1885

March 2, 1885

U. S. R.

Washington, D. C.

Washington, D. C.

Washington, D. C.

James

James

1813 Kentucky Road

1813 Kentucky Road

1813 Kentucky Road

1813 Kentucky Road



400- Columbia Rd., S. E., Wash.

William D. Hall

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1-66

MONTGOMERY COUNTY, MARYLAND										WASHINGTON, D. C.									
01056										01055									
1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON, D. C.</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b>					47.3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>					d. STREET ADDRESS <b>2480 16th. ST. N. W.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>E.</b> Last <b>SHERIDAN</b>					4. DATE OF DEATH Month <b>JAN</b> Day <b>20</b> Year <b>1967</b>														
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/7/ 1892</b>		9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN EHRET</b>					14. MOTHER'S MAIDEN NAME <b>FRANCES SCHIMMEL</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>- - -</b>					17. INFORMANT <b>THOMAS J. SHERIDAN</b> Address <b>SAMES AS # 2</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure - hypertension</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> DUE TO <b>410.9</b> (c) <b>?</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1/14/67</b> , to <b>1/20/67</b> , that (I) (we) last saw the deceased alive on <b>1/19/67</b> , and that death occurred at <b>10:57 AM</b> , from causes and on the date stated above.																			
22a. SIGNATURE <b>Bernard J. Walsh</b>										M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>1/20/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>BERNARD J. WALSH</b>										22d. ADDRESS <b>1800 Capitol Y.W.-D.C.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>1/24/67</b>					23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>					23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEO. CO., MD</b>				
24. FUNERAL DIRECTOR <b>JOSEPH CAWLER SONS</b> <b>5130 WISC. AVE. N. W. WASH., D.C.</b>										25a. REC'D BY REGISTRAR <b>JAN 26 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01057

## CERTIFICATE OF DEATH

01056

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN lb <b>40 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marlow Heights</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>6019 28th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith (None) Shumate</b>				4. DATE OF DEATH Month Day Year <b>January 31 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>31 May 1921</b>	
9. AGE (In years lost, birthday) <b>45 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee Nash</b>				14. MOTHER'S MAIDEN NAME <b>Eula Witmore</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>239-24-8472</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonia (Viral)</b> <b>2000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Reticulum cell sarcoma</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 22</b> , 1966, to <b>Jan. 31</b> , 1967, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Jan. 31</b> , 1967, and that death occurred at <b>2:50</b> M, from causes on and on the date stated above.							
22a. SIGNATURE <b>Martin H. Cohen</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>31 January 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin H. Cohen, MD.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 3rd 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wingate, Wingate, N.C.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wingate, North Carolina</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

01026

100

FOR STATE  
HEALTH DEPT.

01058

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01057

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		d. STREET ADDRESS <b>12826 Camellia Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>William</b>		Middle <b>(nni)</b>		Lost <b>Sims</b>		4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>67</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/3/24</b>		9. AGE (In years last birthday) yrs. <b>42</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CFA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accountant</b>		11. BIRTHPLACE (State or foreign country) <b>Princeton, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Ira Sims</b>				14. MOTHER'S MAIDEN NAME <b>Mary Daisy Laws</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>488-22-8273</b>		17. INFORMANT <b>Ella B. Sims, 12826 Camellia Drive, Silver Spring, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Coronary artery heart disease</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		M.D. <b>Wheaton</b>		DEPUTY MEDICAL EXAMINER <b>Charles Judge</b>		22. DATE SIGNED <b>JAN. 16, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 20, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR <b>John B. Thomas</b>		ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>JAN 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01028

01028



[Faint, mostly illegible text and markings covering the lower half of the page, possibly bleed-through from the reverse side.]



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01059

CERTIFICATE OF DEATH

01058

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>			d. STREET ADDRESS <u>7821 MARION LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MERL</u> Middle <u>FILMORE</u> Last <u>SLIFER</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-09</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PEPCO</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Emory Slifer</u>			14. MOTHER'S MAIDEN NAME <u>Lola Willard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>451X</u> IMMEDIATE CAUSE (a) <u>Cardiac Tamponade</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Dissecting aneurysm aorta</u> DUE TO (c) <u>Medial necrosis, aorta</u>					INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 25, 1966</u> , to <u>Jan 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 10, 1967</u> , and that death occurred at <u>4:12</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Robert N. Coale</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Jan 11, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane, Chevy Chase Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Middletown Luth. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Middletown, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01029

STATE OF OHIO

01029



FOR STATE  
HEALTH DEPT.

01060

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01059

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>16.2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>414 Circle Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stephen Paul Smigosky</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>8</u> - Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-18</u> 9. AGE (In years (last birthday) yrs.) <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TYPEWRITER SERVICE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TYPEWRITER</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>MICHAEL SMIGOSKY</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>578039110</u>		17. INFORMANT <u>Mrs. Anna P. Smigosky (same act?)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of</u> DUE TO (b) <u>Lung</u> DUE TO (c) <u>Pulmonary Emphysema.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>Belden R. Keap M.D.</u> EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		22. DATE SIGNED <u>Jan. 8, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington - Virginia</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Carroll St N.W.</u> DATE <u>JAN 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

622

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BERNARD A. BENTLEY, JR. Jan 8, 1961

01061

CERTIFICATE OF DEATH

01060

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>BROOKE GROVE FOUNDATION</b>		d. STREET ADDRESS <b>7201 ARROWOOD Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>ELSIE A SMITH</b>		4. DATE OF DEATH <b>JANUARY 17 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-16-7789</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank H. Stanwood</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Estelle Farson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Neice Mrs. Carolyn T. Evans</b> <b>581 Phoenix Dr. Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Breast, left</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>With metastases</b> DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-21-1963</b> to <b>1/11/67</b> , that (I) (we) last saw the deceased alive on <b>1967</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>1/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES H. LIGON, MD</b>		22d. ADDRESS <b>SANDY SPRING, MD</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Burial-transit 1-19-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edson Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Lowell, Mass.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> DATE <b>JAN 20 1967</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05019

12010



FOR STATE  
HEALTH DEPT.

01062

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01061

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. LENGTH OF STAY in 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14409 Perrywood Dr.</u>		d. STREET ADDRESS <u>14409 Perrywood Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>FLOYD JACOB SNYDER</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-25 41</u>
9. AGE (In years last birthday) yrs. <u>25</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>HELEN SNYDER (WIFE) (SAME)</u>	
17. INFORMANT <u>Helen Snyder (wife)</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>976X</u> IMMEDIATE CAUSE (a) <u>Gunshot wounds in</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>head with cerebral laceration</u> DUE TO (c) <u>and exsanguination.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, depressed, shot self in head with rifle</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30 PM 1-28 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Burtonsville</u> (County) <u>Montgom.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>1-28-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street, city, town, or county) <u>Wheaton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>I-31-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Thurmont, Fredk. Co. Md</u>
24. FUNERAL DIRECTOR <u>Raymond E. Croager</u>		ADDRESS <u>Thurmont, Md</u>	
25a. REC'D BY REGISTRAR DATE <u>JAN 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01001

01001

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1-18-1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01063 CERTIFICATE OF DEATH 01062											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>190 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Floyd</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Indian Valley</b> d. STREET ADDRESS <b>Route #1, Box 36</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Fay Spence</b>						4. DATE OF DEATH Month Day Year <b>January 24, 19 67</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 July 1942</b>		9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deliverer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William T. Spence</b>						14. MOTHER'S MAIDEN NAME <b>Nora Phillips</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>229-56-8013</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland 20014</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Radiation Pneumonitis</b> DUE TO (c) <b>Hodgkin's Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <b>1 Days</b> <b>4 Weeks</b> <b>1 Year</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>July 18</b> , 19 <b>66</b> , to <b>Jan. 24</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>Jan. 24</b> , 19 <b>67</b> , and that death occurred at <b>6:55</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Leroy Fass</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. <b>AM</b>			22b. DATE SIGNED <b>24 January 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Leroy Fass, MD</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Indian Valley</b>			23d. LOCATION (City, town or county) (State) <b>Indian Valley Va.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md</b>						25a. REC'D BY REGISTRAR <b>JAN 30 1967</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION

53010

01064

## CERTIFICATE OF DEATH

01063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Roger Joseph Squitero</b>				4. DATE OF DEATH <b>1-15-67</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-19-17</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secy. Coin Machine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carmen Squitero</b>				14. MOTHER'S MAIDEN NAME <b>Antoninette Franko</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>079-10-9851</b>		17. INFORMANT <b>Martha Squitero, 1121 N. Belgrade Rd, SS, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>420.1 Acute coronary occlusion</b> IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-15</b> , 19 <b>67</b> , to <b>1-15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-15</b> , 19 <b>67</b> , and that death occurred at <b>1:45P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>John J. Merendino</b>				22b. DATE SIGNED <b>JAN 15, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>John J. Merendino</b>	
22d. ADDRESS <b>11601 NEWPORT MILL RD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas Warner E. Humphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01064**

**01065**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11943 Bluehill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William E. Stanton, Sr.</u>				4. DATE OF DEATH <u>JAN. 11 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-21-1896</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Christopher Stanton</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>W.E. Stanton, Jr. (SON)</u> Address <u>2622 Fetter Lane Bowie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 14, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Palatka, Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Carter</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 16 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01084

Name of Deceased <i>William E. Stanton</i>		Age <i>119</i>	
Sex <i>Male</i>		Race <i>White</i>	
Date of Death <i>Jan. 11, 1917</i>		Place of Death <i>Stanton, N.C.</i>	
Cause of Death <i>Heart Failure</i>		Disease or Injury <i>None</i>	
Signature of Medical Examiner <i>W. E. Stanton</i>		Signature of Coroner <i>W. E. Stanton</i>	
Date of Signature <i>Jan. 11, 1917</i>		Date of Signature <i>Jan. 11, 1917</i>	

01066

## CERTIFICATE OF DEATH

01065

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>				d. STREET ADDRESS <b>Cider Barrel Trailer Court, Box 193112</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Ann Starenchak</b>				4. DATE OF DEATH Month Day Year <b>January 17, 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 May 1940</b>	
9. AGE (In years lost birthday) <b>26 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jessie Kaylor</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Wineman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>205-34-7684</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland 20014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myelogenous Leukemia</b> DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hepatic necrosis</b> DUE TO (c) <b>Extensive ulceration of small intestine mucosa</b>						INTERVAL BETWEEN ONSET AND DEATH <b>17 Days</b> <b>3 Days</b> <b>24 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Septicemia ?</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>January 11, 1967</b> , to <b>January 17, 1967</b> , that (X) (we) last saw the deceased alive on <b>Jan. 17, 1967</b> , and that death occurred at <b>4:30 P.M.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Jerry L. Spivak</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 17, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-20-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Scottdale Penna</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Co.</b>		ADDRESS <b>1400 Chapin St. N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

01067

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5317 Worthington Drive</b>			d. STREET ADDRESS <b>5317 Worthington Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Whitley Suber</b>			4. DATE OF DEATH Month Day Year <b>January 13, 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9-15-1906</b>		9. AGE (In years last birthday) <b>60</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>College Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Geo. Wash. Univ.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mississippi</b>	
13. FATHER'S NAME <b>Robert Lee Suber</b>			14. MOTHER'S MAIDEN NAME <b>Nora Hannah</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>579-54-7694</b>		17. INFORMANT <b>Edna Swenson Suber- See Item No. 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>1 year</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , 19____, to <b>January 13, 1967</b> , that (I) (we) lost saw the deceased alive on <b>January 3, 1967</b> , and that death occurred at <b>11:30 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>John F. Gustafson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>January 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John F. Gustafson</b>		22d. ADDRESS <b>915 19th Street, N.W.; Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave. N.W., Wash. DC.</b>		25a. REC'D BY REGISTRAR <b>JAN 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01007

01008

CONFIDENTIAL

FOR STATE  
HEALTH DEPT

01069

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01068

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Do A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>3107 82nd Av.</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard Philip Sullivan</u>		4. DATE OF DEATH <u>Jan 11 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/23</u>
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCTION MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FAIRCHILD HILLER ELECTRONICS</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FRANK B. SULLIVAN</u>		14. MOTHER'S MAIDEN NAME <u>ALICE C. O'LEARY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W. II 727 03 2833</u>	
17. INFORMANT <u>ESTHER E. SULLIVAN</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Recent + Remote</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/11/67</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JAN 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHRE CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>N. ANDOVER, MASS.</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Pimordale Md</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01809

01809

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

01070

## CERTIFICATE OF DEATH

01069

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY in 1b <b>2 1/2 mos.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>				d. STREET ADDRESS <b>5913 Ipswich Road</b>	
3. NAME OF DECEASED (Type or print) <b>Jeannette Clara Swain</b>			4. DATE OF DEATH <b>1/1/1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/1887</b>	9. AGE (In years last birthday) <b>88</b>	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Henry Nau</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-54-8434</b>		17. INFORMANT <b>Mrs. Elsie Stewart, 5913 Ipswich Rd., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO (b) <b>Generalized circulatory failure</b> DUE TO (c) <b>Senility</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 20</b> , 19 <b>66</b> , to <b>Jan 1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan 1</b> , 19 <b>67</b> , and that death occurred at <b>9:30 AM</b> , from causes on and on the date stated above.					
22a. SIGNATURE <b>John F. Harrington</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John F. Harrington</b>		22d. ADDRESS <b>3810-12 2nd Washington St</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-5-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	
23d. LOCATION (City or Town) <b>Washington, D. C.</b>		23e. LOCATION (County) (State)			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07050

03010

variation

2020

• **BONE**

small, slender, stemless

James M. Smith

• 2004

2000

1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 26

0740-7030

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01071

CERTIFICATE OF DEATH

01070

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. of C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>43hrs 55min</u>		d. STREET ADDRESS <u>135 Longfellow St., N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Virginia</u> Last <u>Swink</u>		4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 2, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nelson Follin</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. French</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George C. Swink</u> Address <u>2008 Georgia Ave Silver Spring, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X CVA</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Squamous ca of larynx - 15 yrs ago - no evidence of recurrence</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	20c. TIME OF INJURY Month, Day, Year <u>  </u> Hour o.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>	21. I certify that (1) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>Jan 11</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Jan 10</u> , 19 <u>67</u> , and that death occurred at <u>12:25</u> AM, from causes and on the date stated above.	
22a. SIGNATURE <u>R. H. Sandstrom</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom MD.</u>	22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>	23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>Jan. 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. ADDRESS <u>8434 Georgia Ave Silver Spring, Md</u>		DATE <u>JAN 16 1967</u>	

01070

STATE OF TEXAS

01071

County of \_\_\_\_\_

Home \_\_\_\_\_

CLB

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

01072

CERTIFICATE OF DEATH

01071

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> 16-2 d. STREET ADDRESS <u>7228 Patterson Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest</u> <u>monroe</u> <u>Teague</u>			4. DATE OF DEATH Month Day Year <u>January</u> <u>18</u> <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-06</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Manager -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Toledo Scale Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Oscar TEAGUE</u>		
14. MOTHER'S MAIDEN NAME <u>Martha Idle</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>1927-1931</u>		
16. SOCIAL SECURITY NO. <u>299-09-9588</u>			17. INFORMANT <u>Records - Washington Sanitarium &amp; Hospital</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR Hemorrhage</u> DUE TO (b) <u>UREMIA - HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROTIC CEREBRO-RENAL-VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>331X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>64</u> , to <u>JAN 18</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>JAN 18</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> AM, from causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>			22b. DATE SIGNED <u>1-18-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>			22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>21 Jan 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort LINCOLN</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MD</u>		
24. FUNERAL DIRECTOR <u>W. W. Chambers Co. Riverdale, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>JAN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

10101

STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01073

CERTIFICATE OF DEATH

01072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>4 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>10401 Grosvenor Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph C. Thoma</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1883</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Engr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Woodbury, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ferdinand G. Thoma</u>		14. MOTHER'S MAIDEN NAME <u>Ida Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>094-20-4712</u>	
17. INFORMANT <u>Mrs. Jane Hall</u> Address <u>6021 Rossmore Dr Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>HYPERTENSION</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>59</u> , to <u>JAN</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JAN 29</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Leo J. Dunovan</u>		22b. DATE SIGNED <u>1/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR LEO J DUNOVAN</u>		22d. ADDRESS <u>8218 WISCONSIN AVE BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 2 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01073

01074

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General</b>		e. STREET ADDRESS <b>Rt. 2, Box 185</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>MCKINLEY</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>1</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>separated</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/94</b>
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Ida Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>218-20-1430</b>	
17. INFORMANT <b>Hospital Records, Olney, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1443X Apoplexy, hemorrhagic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b> <b>15 yrs</b> <b>15 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 1966</b> to <b>Jan 19, 1967</b> , that I last saw the deceased alive on <b>Jan 19, 1967</b> , and that death occurred at <b>7:00 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>A. Dement Bonifant</b> M.D. <b>Sandy Spry, med.</b> <b>1/20/67</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>24 Jan 1967</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		24a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01073

CERTIFICATE OF DEATH

01073

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/31		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. RACE White		9. RELIGION None		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Memphis, Tenn.		14. DATE OF DEATH 4/4/68		15. TIME OF DEATH 10:10 AM	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None	
21. SIGNATURE OF REGISTRAR None		22. SIGNATURE OF CLERK None		23. SIGNATURE OF NOTARY None		24. SIGNATURE OF JUDGE None		25. SIGNATURE OF SHERIFF None	
26. SIGNATURE OF DISTRICT ATTORNEY None		27. SIGNATURE OF COUNTY CLERK None		28. SIGNATURE OF CITY CLERK None		29. SIGNATURE OF VICE MAYOR None		30. SIGNATURE OF MAYOR None	
31. SIGNATURE OF CHIEF OF POLICE None		32. SIGNATURE OF DEPUTY CHIEF OF POLICE None		33. SIGNATURE OF SHERIFF DEPUTY None		34. SIGNATURE OF JAILER None		35. SIGNATURE OF PRISON WARDEN None	
36. SIGNATURE OF PRISON CHIEF None		37. SIGNATURE OF PRISON CLERK None		38. SIGNATURE OF PRISON WARDEN None		39. SIGNATURE OF PRISON CHIEF None		40. SIGNATURE OF PRISON CLERK None	
41. SIGNATURE OF PRISON WARDEN None		42. SIGNATURE OF PRISON CHIEF None		43. SIGNATURE OF PRISON CLERK None		44. SIGNATURE OF PRISON WARDEN None		45. SIGNATURE OF PRISON CHIEF None	
46. SIGNATURE OF PRISON CLERK None		47. SIGNATURE OF PRISON WARDEN None		48. SIGNATURE OF PRISON CHIEF None		49. SIGNATURE OF PRISON CLERK None		50. SIGNATURE OF PRISON WARDEN None	
51. SIGNATURE OF PRISON CHIEF None		52. SIGNATURE OF PRISON CLERK None		53. SIGNATURE OF PRISON WARDEN None		54. SIGNATURE OF PRISON CHIEF None		55. SIGNATURE OF PRISON CLERK None	
56. SIGNATURE OF PRISON WARDEN None		57. SIGNATURE OF PRISON CHIEF None		58. SIGNATURE OF PRISON CLERK None		59. SIGNATURE OF PRISON WARDEN None		60. SIGNATURE OF PRISON CHIEF None	
61. SIGNATURE OF PRISON CLERK None		62. SIGNATURE OF PRISON WARDEN None		63. SIGNATURE OF PRISON CHIEF None		64. SIGNATURE OF PRISON CLERK None		65. SIGNATURE OF PRISON WARDEN None	
66. SIGNATURE OF PRISON CHIEF None		67. SIGNATURE OF PRISON CLERK None		68. SIGNATURE OF PRISON WARDEN None		69. SIGNATURE OF PRISON CHIEF None		70. SIGNATURE OF PRISON CLERK None	
71. SIGNATURE OF PRISON WARDEN None		72. SIGNATURE OF PRISON CHIEF None		73. SIGNATURE OF PRISON CLERK None		74. SIGNATURE OF PRISON WARDEN None		75. SIGNATURE OF PRISON CHIEF None	
76. SIGNATURE OF PRISON CLERK None		77. SIGNATURE OF PRISON WARDEN None		78. SIGNATURE OF PRISON CHIEF None		79. SIGNATURE OF PRISON CLERK None		80. SIGNATURE OF PRISON WARDEN None	
81. SIGNATURE OF PRISON CHIEF None		82. SIGNATURE OF PRISON CLERK None		83. SIGNATURE OF PRISON WARDEN None		84. SIGNATURE OF PRISON CHIEF None		85. SIGNATURE OF PRISON CLERK None	
86. SIGNATURE OF PRISON WARDEN None		87. SIGNATURE OF PRISON CHIEF None		88. SIGNATURE OF PRISON CLERK None		89. SIGNATURE OF PRISON WARDEN None		90. SIGNATURE OF PRISON CHIEF None	
91. SIGNATURE OF PRISON CLERK None		92. SIGNATURE OF PRISON WARDEN None		93. SIGNATURE OF PRISON CHIEF None		94. SIGNATURE OF PRISON CLERK None		95. SIGNATURE OF PRISON WARDEN None	
96. SIGNATURE OF PRISON CHIEF None		97. SIGNATURE OF PRISON CLERK None		98. SIGNATURE OF PRISON WARDEN None		99. SIGNATURE OF PRISON CHIEF None		100. SIGNATURE OF PRISON CLERK None	

1. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health and Human Services, State of Tennessee, and that the same has been compared with the original and found to be correct.

2. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health and Human Services, State of Tennessee, and that the same has been compared with the original and found to be correct.

3. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health and Human Services, State of Tennessee, and that the same has been compared with the original and found to be correct.

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6. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health and Human Services, State of Tennessee, and that the same has been compared with the original and found to be correct.

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10. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health and Human Services, State of Tennessee, and that the same has been compared with the original and found to be correct.

01075

## CERTIFICATE OF DEATH

01074

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 151	
c. LENGTH OF STAY IN 1b <u>26 days</u>		d. STREET ADDRESS <u>2016 Forest Dale Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert G. Thompson, Sr.</u>		4. DATE OF DEATH <u>January 10</u> 1967	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1898</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. U. S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>262-54-2511-7</u>	
17. INFORMANT <u>Robert G. Thompson, Jr.</u>		Address <u>2016 Forest Dale Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular failure</u> DUE TO <u>coronary vascular accident</u> (b) <u>arteriosclerosis</u> DUE TO <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>One month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary insufficiency + Renal insufficiency + uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-15</u> , 19 <u>66</u> , to <u>1-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-9</u> , 19 <u>67</u> , and that death occurred at <u>3 A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Veronica Troost MD</u>		22b. DATE SIGNED <u>1-10-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST</u>		22d. ADDRESS <u>10236 N. H. ave. SS. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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EXTRACT OF DEED

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01076

CERTIFICATE OF DEATH

01075

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>6 Hours 41 Minutes</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San &amp; Hospital</b>		d. STREET ADDRESS <b>7902 Holstein St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Elbert Middle Lamar Last Timberlake</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 9, 1967</b>
9. AGE (In years lost birthday) <b>6 Hours</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>41</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Lamar Timberlake</b>		14. MOTHER'S MAIDEN NAME <b>Doris Ann Beasley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Edward Timberlake</b>		Address <b>7902 Holstein St., T.P. Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>762.5 IMMEDIATE CAUSE (a) Anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Failure of lung expansion</b> DUE TO (c) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>From birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Lester L. Mohr</b>		22b. DATE SIGNED <b>1/10/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Mohr, M.D.</b>		22d. ADDRESS <b>7600 Carroll Ave., Takoma Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-11-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington San &amp; Hospital</b>		23d. LOCATION (City or Town) (County) (State) <b>Takoma Park, Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>H.S. Nelson, 7600 Carroll Ave., Takoma Park, Md</b>		25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Jr.</b>			

7-203489

01075

01075

INSTITUTE OF DESIGN

Montgomery

Montgomery

Montgomery

2 Hours

2 Hours

Washington State Hospital

2 Hours

7502 Holstein St.

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January 1950

January 1950

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7502 Holstein St., Y.P. 20

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01077

CERTIFICATE OF DEATH

01076

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		d. STREET ADDRESS <u>2701 SILVERDALE DR.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>HELEN</u> Middle <u>K</u> Last <u>TRAINOR</u>		<b>4. DATE OF DEATH</b> Month <u>JAN</u> Day <u>6</u> Year <u>1967</u>	
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-22</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shroop, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Komar</u>		14. MOTHER'S MAIDEN NAME <u>Rose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eugene F. Trainor (same as #2.)</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multifocal leukoencephalopathy</u> DUE TO <u>201X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hodgkin's Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>Dec</u> , 19 <u>66</u> , to <u>1/5</u> , 19 <u>67</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>1/6</u> , 19 <u>67</u> , and that death occurred at <u>6:15</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>1/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. LEONARD GOLD</u>		22d. ADDRESS <u>8641 Collesville Road, Silver Sp. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Date of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery County Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John Walters</u>		25c. REGISTRAR'S SIGNATURE <u>John Walters</u>	

25040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01078

CERTIFICATE OF DEATH

01077

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>550 EDNOR ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>LYDIA</b> Middle <b>(NMN)</b> Last <b>TUCKER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>12,</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/80</b>
9. AGE (In years lost birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF-EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT OWNER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN TUCKER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN MURPHY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema, cont.</b> DUE TO (b) <b>arterio-sclerotic cardiac vascular disease</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>30 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia of undetermined origin</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>56</b> , to <b>Jan</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan 12</b> , 19 <b>67</b> , and that death occurred at <b>9:15 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A.D. Bonifant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A.D. BONIFANT, M.D.</b>		22d. ADDRESS <b>MEDICAL CENTER, SANDY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 16, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bartonsville, Md.</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters Washington, D.C. 20012</b>		25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01078

01078

STATE OF DEATH

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CLIFFE JONES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01079

CERTIFICATE OF DEATH

01078

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>about 22 hours.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>9908 Merwood Lane,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>(NMD)</b> Last <b>Tudge</b>		4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1873</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John Weigel</b>		14. MOTHER'S MAIDEN NAME <b>Caroline (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-03-011292</b>	
17. INFORMANT <b>Mrs. Helen Mastbrook</b>		Address <b>9908 Merwood Lane S.S.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERY DISEASE - ATHEROSCLEROSIS</b> (c) <b>PNEUMONIA, LEFT BASE, PROBABLE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3/63</b> <b>5-6 YRS.</b> <b>3-4 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AVRICULAR FIBRILLATION, CHRONIC. MYOCARDIAL INFARCTION 1963</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov., 5, 1957</b> to <b>Jan., 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan., 18, 1967</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James A. Roberts</b>		22b. DATE SIGNED <b>1/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James A. Roberts, M.D.</b>		22d. ADDRESS <b>8907 Georgia Ave., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Snitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

01079

CERTIFICATE OF DEATH

01079

3163

CERTIFICATE OF DEATH

2-6-1941

CERTIFICATE OF DEATH

2-4-1941

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

01080

Items #3 & 14 Film #G385 1/24/67 pc

CERTIFICATE OF DEATH

01079

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN lb <u>Kensington, Maryland 151</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>3401 Univ. Blvd. W</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY/ Bonnie Lynn Van Meter</u>				4. DATE OF DEATH Month Day Year <u>1 15 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/15/67</u>		9. AGE (In years last birthday) yrs. <u>34</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Mont. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Hugh Van Meter</u>				14. MOTHER'S MAIDEN NAME <u>Sherry Kelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOVE</u>		17. INFORMANT <u># 13</u>		Address <u>#2 d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrops FETALIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hemolytic Disease of Newborn</u> DUE TO (c) <u>Rh Incompatibility</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>William F. Colliton</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>15 Jan 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Colliton Jr.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home. 300 4th NE. Wash, DC.</u>				25a. REC'D BY REGISTRAR <u>JAN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01010

CERTIFICATE OF DEATH

01080

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Manner of death: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of registration: [illegible]

1. Name of deceased: [illegible]		2. Sex: [illegible]		3. Age: [illegible]	
4. Date of birth: [illegible]		5. Place of birth: [illegible]		6. Date of death: [illegible]	
7. Place of death: [illegible]		8. Cause of death: [illegible]		9. Manner of death: [illegible]	
10. Signature of physician: [illegible]		11. Signature of registrar: [illegible]		12. Date of registration: [illegible]	
13. [illegible]		14. [illegible]		15. [illegible]	
16. [illegible]		17. [illegible]		18. [illegible]	
19. [illegible]		20. [illegible]		21. [illegible]	
22. [illegible]		23. [illegible]		24. [illegible]	
25. [illegible]		26. [illegible]		27. [illegible]	
28. [illegible]		29. [illegible]		30. [illegible]	
31. [illegible]		32. [illegible]		33. [illegible]	
34. [illegible]		35. [illegible]		36. [illegible]	
37. [illegible]		38. [illegible]		39. [illegible]	
40. [illegible]		41. [illegible]		42. [illegible]	
43. [illegible]		44. [illegible]		45. [illegible]	
46. [illegible]		47. [illegible]		48. [illegible]	
49. [illegible]		50. [illegible]		51. [illegible]	
52. [illegible]		53. [illegible]		54. [illegible]	
55. [illegible]		56. [illegible]		57. [illegible]	
58. [illegible]		59. [illegible]		60. [illegible]	
61. [illegible]		62. [illegible]		63. [illegible]	
64. [illegible]		65. [illegible]		66. [illegible]	
67. [illegible]		68. [illegible]		69. [illegible]	
70. [illegible]		71. [illegible]		72. [illegible]	
73. [illegible]		74. [illegible]		75. [illegible]	
76. [illegible]		77. [illegible]		78. [illegible]	
79. [illegible]		80. [illegible]		81. [illegible]	
82. [illegible]		83. [illegible]		84. [illegible]	
85. [illegible]		86. [illegible]		87. [illegible]	
88. [illegible]		89. [illegible]		90. [illegible]	
91. [illegible]		92. [illegible]		93. [illegible]	
94. [illegible]		95. [illegible]		96. [illegible]	
97. [illegible]		98. [illegible]		99. [illegible]	
100. [illegible]		101. [illegible]		102. [illegible]	

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01081

## CERTIFICATE OF DEATH

01080

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15.1</u> d. STREET ADDRESS <u>5817 Bradley Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Kleofa B. Veresicka</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Jan 7 1967</u>	
<b>5. SEX</b> <u>7</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/21/1986</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>80</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lithuania</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Lithuania</u>		<b>13. FATHER'S NAME</b> <u>Vincent Daudovasa</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Babara</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> Address <u>Same as above</u> <u>Daughter Felicia Platons</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Pneumonia</u> <u>451X</u> DUE TO (b) <u>(2) Cerebrovascular accident</u> DUE TO (c) <u>(3) Arteriosclerosis? Dissecting aneurysm</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u> <u>3 weeks</u> <u>&gt; 1 year</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/10</u> , 19 <u>66</u> , to <u>1/6</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>1/6</u> , 19 <u>67</u> , and that death occurred on <u>1/6</u> A.M., from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Allen J. O'Neill</u>		<b>22b. DATE SIGNED</b> <u>1/7/1967</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Allen J. O'Neill</u>		<b>22d. ADDRESS</b> <u>8601 Old Georgetown Rd Bethesda Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>1-10-67</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>	<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Washington, D. C. and</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 13 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08010

**ACKNOWLEDGMENTS**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01082

## CERTIFICATE OF DEATH

01081

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47.3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN &amp; Hospital</u>				d. STREET ADDRESS <u>2959 MILLS AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEONELDA</u> Middle <u>GRACE</u> Last <u>VOLKMAN</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 4 1894</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting Clerk- Navy Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Connecticut D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB CHARLES LESHER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-64-9960</u>		17. INFORMANT <u>CHART</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Lymphoma</u> 200.2 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-29-1966</u> , to <u>1-20-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-20-67</u> 19 <u>67</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitlock</u>				22b. DATE SIGNED <u>1-20-67</u>		22c. PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>	
22d. ADDRESS <u>7700 Carroll Avenue</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>S. H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>2901 14-1-67</u>		25b. REGISTRAR'S SIGNATURE <u>James M. Whitlock</u>	

18010

01032

0000-0000

1000 General Average

1000 General Average

1000 General Average



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01083

CERTIFICATE OF DEATH

01082

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, DC</b> b. COUNTY <b>Washington, DC</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>25 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, DC</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US Naval Hospital</b>			d. STREET ADDRESS <b>2540 Massachusetts Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Caroline Thom Walsh</b>			4. DATE OF DEATH Month Day Year <b>Jan 8 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jun. 2, 1904</b>		9. AGE (In years last birthday) <b>62</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>	
13. FATHER'S NAME <b>Corcoran Thom</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-28-89-91</b>		17. INFORMANT Address <b>Robert Walsh 2540 Mass. Ave. Washington DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive GI hemorrhage</b> 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute duodenal ulcer</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Temporo-parietal intracerebral hematoma</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs (approx)</b> <b>1 wk (approx)</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 14</b> , 19 <b>66</b> to <b>Jan. 8</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Jan. 8</b> , 19 <b>67</b> , and that death occurred at <b>7:04 P.</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Evans Diamond</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EVANS DIAMOND</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-12-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's &amp; Sons Washington, DC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, when please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01084

CERTIFICATE OF DEATH

01083

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>30 Woodlawn Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willard Bruce Walters</u>		4. DATE OF DEATH <u>JAN 5 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-76</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from R &amp; H</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Unknown BRUCE WALTERS</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-52-4044</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 27</u> , 19 <u>66</u> , to <u>1/5/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/4/67</u> , 19 <u>67</u> , and that death occurred at <u>11:58</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED <u>1/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jan. 9-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lack Creek</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Matthew Walters Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 9 1967</u>	

01083

STATE OF CALIFORNIA

01083



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01085

01084

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8001 Newdale Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>8001 Newdale Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Howardine Ward</b>				4. DATE OF DEATH Month <b>January</b> Day <b>16</b> , Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-12-1886</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Marcellus Gardiner</b>				14. MOTHER'S MAIDEN NAME <b>N. Howard</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-50-9482</b>		17. INFORMANT <b>Henry T. Ward-See Item No. 2</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c) <b>Arterio-sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis Deformans</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the undersigned) attended the deceased from <b>April 26, 1966</b> , to <b>Jan. 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 7, 1967</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>John P. De Mayo</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>John L. DeMayo, M.D.</b> 22d. ADDRESS <b>5632 Bradley Blvd., Bethesda, Md. 20014</b> 22e. DATE SIGNED <b>JAN 20 1967</b> 22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-18-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery/ Silver Spring, Md.</b>		23d. LOCATION (City, town or county) (State) <b>Bethesda, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>				25a. REC'D BY REGISTRAR <b>JAN 20 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01086

## CERTIFICATE OF DEATH

01085

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>WEBSTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb <b>14 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First Middle Last <b>DALLAS WARD</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 22 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 APRIL 1922</b>
9. AGE (In years and birth day) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>22 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. MARINE CORPS</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>RICHWOOD, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>CARE WARD</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIA BRINKLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES APR 41 MAY 65</b>		16. SOCIAL SECURITY NO. <b>235 22 2912</b>	
17. INFORMANT <b>MRS. SARAH WARD, WEBSTER SPRINGS, W.VA.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8 JAN 1967</b> to <b>22 JAN 1967</b> , that (I) (we) last saw the deceased alive on <b>22 JAN 1967</b> , and that death occurred at <b>1225 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>P. Kirchner</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>P. KIRSCHNER, LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND</b>	
23a. BURIAL, CREMATION, REBURY, etc. <b>REBURY</b>	23b. DATE THEREOF <b>1-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Point Mountain</b>	23d. LOCATION (City or Town) (County) (State) <b>Webster Springs, W. Va.</b>
24. FUNERAL DIRECTOR <b>R. A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1967</b>	
ADDRESS <b>7557 WISCONSIN AVE, BETHESDA, MD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01087

CERTIFICATE OF DEATH

01086

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville P.O. 15.1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>13116 Parkland</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>23</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/18</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Kline</u>		14. MOTHER'S MAIDEN NAME <u>Ellen T Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Milton C Warren sr</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory depression</u> DUE TO <u>330X</u> (b) <u>increased intracranial pressure</u> DUE TO <u>bleeding aneurysm</u> (c) <u>bleeding aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>60</u> , to <u>1/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> , 19 <u>67</u> , and that death occurred at <u>7:35 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Richard Delaney</u>		22b. DATE SIGNED <u>1/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>4323/H Richard Delaney, M.D.</u>		22d. ADDRESS <u>4323 Havard St., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Washington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

01085

DEPARTMENT OF STATE

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01088

## CERTIFICATE OF DEATH

01087

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1220 Blair Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>BERTHA</b> First Middle Last		4. DATE OF DEATH <b>January 27, 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 10, 1899</b>
9. AGE (In years last birthday) yrs. <b>67</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Ahrenberg</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-30-8887</b>	
17. INFORMANT <b>Sallie W. Cushner</b>		1307 <sup>Address</sup> <b>Idylwood Rd. Pikesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO <b>Coronary insufficiency</b> DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1959</b> <b>1959</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April, 1961</b> , to <b>12/23, 1966</b> that (I) (we) last saw the deceased alive on <b>12/23, 1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Jack P. Segal</b>		22b. DATE SIGNED <b>1/27/67</b>	22c. PHYSICIAN'S NAME (Type) <b>JACK P. SEGAL, M. D.</b>
22d. ADDRESS <b>5323 Connecticut Ave., N.W. Washington, D. C.</b>		22e. REC'D BY REGISTRAR <b>J Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>
24. FUNERAL DIRECTOR <b>GOLDBERG FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

MEDICAL CERTIFICATION

CLEARED BY DOCTOR REAP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01089

CERTIFICATE OF DEATH

01088

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>-1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b> <b>151</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Route #1, Box #71</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Basil</b> Middle <b>Worthington</b> Last <b>Waters, Sr.</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1877</b>		9. AGE (In years lost birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ret. Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas W. Waters</b>				14. MOTHER'S MAIDEN NAME <b>Mary Magruder</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-54-7119</b>		17. INFORMANT <b>Medical Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Apoplexy, hemorrhagic</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>20 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1965, to <b>Jan</b> , 1967, that (I) (we) least saw the deceased alive on <b>Jan 20</b> , 1967, and that death occurred at <b>10:50 A.M.</b> causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M.D.</b>				22d. ADDRESS <b>Medical Center, Sandy Springs, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-23-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		23d. LOCATION (City or Town) (County) (State) <b>Olney, Maryland</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. RECEIVED BY REGISTRAR <b>JAN 24 1967</b> DATE	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

28010

1997

1-2-57  
24. John  
Laytonville, Mo.

27. 10/1/92

Oliver, Mary Jane

01090

CERTIFICATE OF DEATH

01089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>	
c. LENGTH OF STAY IN 1b <b>18 YRS</b>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>17521 Old BALTO. ROAD</b>		d. STREET ADDRESS <b>17521 Old Baltimore Road</b>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR</b> First <b>AUGUSTUS</b> Middle <b>WEIDNER</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 17, 1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARCHITECT</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Housing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CAMDEN, NEW JER</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WALTER WEIDNER</b>		14. MOTHER'S MAIDEN NAME <b>BLANCHE SNYDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>579-48-7019</b>	
17. INFORMANT <b>WIFE</b> <b>Ethel R. Weidner</b> Address <b>SAME as above # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b> DUE TO <b>ACUTE CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ASCVD - H.C.V.D.</b> DUE TO <b>10 YRS</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1964</b> to <b>Jan 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 13, 1967</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Donald R. Lewis</b>		22b. DATE SIGNED <b>Jan 18, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Lewis, M.D.</b>		22d. ADDRESS <b>700 Cloverly St. Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>JAN 23 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01089

EXHIBIT OF DATA

01089

1. Name of the person or organization		2. Address		3. City		4. State		5. Zip	
6. Date of birth		7. Date of death		8. Date of entry		9. Date of exit		10. Date of return	
11. Name of the person or organization		12. Address		13. City		14. State		15. Zip	
16. Date of birth		17. Date of death		18. Date of entry		19. Date of exit		20. Date of return	
21. Name of the person or organization		22. Address		23. City		24. State		25. Zip	
26. Date of birth		27. Date of death		28. Date of entry		29. Date of exit		30. Date of return	
31. Name of the person or organization		32. Address		33. City		34. State		35. Zip	
36. Date of birth		37. Date of death		38. Date of entry		39. Date of exit		40. Date of return	
41. Name of the person or organization		42. Address		43. City		44. State		45. Zip	
46. Date of birth		47. Date of death		48. Date of entry		49. Date of exit		50. Date of return	
51. Name of the person or organization		52. Address		53. City		54. State		55. Zip	
56. Date of birth		57. Date of death		58. Date of entry		59. Date of exit		60. Date of return	
61. Name of the person or organization		62. Address		63. City		64. State		65. Zip	
66. Date of birth		67. Date of death		68. Date of entry		69. Date of exit		70. Date of return	
71. Name of the person or organization		72. Address		73. City		74. State		75. Zip	
76. Date of birth		77. Date of death		78. Date of entry		79. Date of exit		80. Date of return	
81. Name of the person or organization		82. Address		83. City		84. State		85. Zip	
86. Date of birth		87. Date of death		88. Date of entry		89. Date of exit		90. Date of return	
91. Name of the person or organization		92. Address		93. City		94. State		95. Zip	
96. Date of birth		97. Date of death		98. Date of entry		99. Date of exit		100. Date of return	

01091

## CERTIFICATE OF DEATH

01090

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>1571</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10226 Carroll Place</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10226 Carroll Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John P. Wetherill, III</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1902</b>	9. AGE (In years last birthday) <b>64</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patent Attorney</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patent Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ira Cortright Wetherill</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Campbell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>Wetherill</b> <b>Genevieve Rusk-Wife- See Item No. 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with coronary thrombosis (Mar. 1, 1966)</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>42.11 mo.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Spontaneous pneumothorax Jan 1965 - Pleural thickening</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , 19 _____, to <b>Jan. 15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 14</b> , 19 <b>67</b> , and that death occurred at <b>530</b> M. from causes on and on the date stated above.							
22a. SIGNATURE <b>R. Massie Page</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 16 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. Massie Page, M. D.</b>		22d. ADDRESS <b>1835 Eye Street, NW Wash., D. C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>				
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00010

CERTIFICATE OF DEATH

01031

Blank certificate form with horizontal lines and a large circular stamp in the center.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

01092

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01091

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b> 13.2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Vonder Wettern</b> First Middle Last 5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9/19/92</b> 9. AGE (In years lost birthday) <b>74 yrs.</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		4. DATE OF DEATH Month Day Year <b>1 29 19 67</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME <b>William Wettern</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b> 16. SOCIAL SECURITY NO. <b>211-20-6915</b> 17. INFORMANT <b>Montg. General Hosp. Records, Olney, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO (b) <b>Cardiac Pump failure</b> DUE TO (c) <b>Ruptured ventricle - Coronary thrombosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>5/1/29</b> , 19 <b>67</b> , to <b>1/29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>67</b> , and that death occurred at <b>11:25 AM</b> from causes and on the date stated above.	
22a. SIGNATURE <b>Charles S. Whitaker</b> 22c. PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Clarksville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2-1-1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		23d. LOCATION (City or Town) (County) (State) <b>Glenelg, Md</b>	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

12010

01032

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01093

CERTIFICATE OF DEATH

01092

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hosp.</b>				d. STREET ADDRESS <b>1401 Blair Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>IRVING</b> Middle <b>-----</b> Last <b>WEXLER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1911</b>		
				9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Israel</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tzvi Wexler</b>				14. MOTHER'S MAIDEN NAME <b>Rose Hirsh</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>114-05-3472</b>		17. INFORMANT <b>Jerome Wexler</b> Address <b>Bowie, 3628 Majestic Lane Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Now</b> , 19 <b>67</b> , to <b>present</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>2/10</b> 19 <b>66</b> , and that death occurred at <b>1A</b> M, from causes and on the date stated above.								
22a. SIGNATURE <b>Herbert Wexler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/20/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Herbert Wexler</b>				22d. ADDRESS <b>1800 Eye St NW Wash DC</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>		
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home 4217 9th Street N.W.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

Cleared with Doctor Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20010

10000

RECEIPT OF DEPOSIT

DATE	10/10/11
AMOUNT	100.00
TO THE ORDER OF	John Doe
PAID TO ORDER	100.00
REMARKS	For cash on hand

Bank of America  
100 Main Street  
New York, NY 10001

~~Handwritten signature~~  
10/10/11  
100.00  
John Doe  
100 Main Street  
New York, NY 10001

01094

## CERTIFICATE OF DEATH

01093

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>13 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> <u>16.2</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>3707 DONNELL DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Ford</u> Last <u>Wight</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 20, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years lost birthday) yrs. <u>13</u> <u>1</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edward Wight</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Edward White</u> Address <u>Same as 2D</u> <u>Forestville, Maryland</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Prematurity - Immaturity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> , 19 <u>67</u> , to <u>1-20</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>1-20</u> 19 <u>67</u> , and that death occurred at <u>9:45 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. R. CONLEY</u>		22d. ADDRESS <u>5716 Howard Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - Washington, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

6010

32010



01095

## CERTIFICATE OF DEATH

01094

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>38 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>3707 Donnell Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lyndon</u> Last <u>Wight</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>January 29 1967</u>		9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Wight</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Ford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward Wight</u>		Address <u>Smyers 2D, Forestville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Immaturity - Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> , 19 <u>67</u> , to <u>1-22</u> , 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>1-22</u> , 19 <u>67</u> , and that death occurred at <u>11:20</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>McConley</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. R. Conley</u>				22d. ADDRESS <u>3716 Howard Lane, Kensington, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/25/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01095

FOR STATE  
HEALTH DEPT.

01096

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>9 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12412 Village Square Terrace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Wallace</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1928</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>		11. BIRTHPLACE (State or foreign country) <u>White Plains, New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward W. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Babcock Weigand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>555-34-2821</u>		17. INFORMANT <u>Mrs. Marjorie Babcock-Mother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>with cerebral laceration</u> (a), stating the underlying cause lost. DUE TO <u>and exsanguination</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased shot self in head when served with warrant by police.</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:45 P.M. 1-28 1967</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Rockville, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>Jan 31, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	
				22d. LOCATION (City, town, or county) <u>Prince Georges Co., Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u>				24a. REC'D BY REGISTRAR <u>FEB 1 1967</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	
24c. ADDRESS <u>Warner E. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.</u>							

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

01097

01096

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Md. Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>minutes</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>12226 Dalewood Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Frank Edward Williams</b>				4. DATE OF DEATH <b>January 26 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/24/24</b>	
				9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Sheriff Montgomery</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery County Govt.</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Carl Williams</b>				14. MOTHER'S MAIDEN NAME <b>Mae Queen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>				16. SOCIAL SECURITY NO. <b>248-24-0511</b>			
17. INFORMANT <b>Lena Williams 12226 Dalewood Drive Wheaton, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, massive</b> DUE TO (b) <b>Myocardial infarction (old)</b> DUE TO (c) <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 8, 1960</b> to <b>Jan 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 19, 1967</b> and that death occurred at <b>11:00</b> M. from causes and on the date stated above.							
22a. SIGNATURE <b>George L. Ball</b>				22b. DATE SIGNED <b>Jan 26, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>George L. Ball</b>				22d. ADDRESS <b>10920 Georgia Ave Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Clark E. Wisor Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>JAN 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01098					01097				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>New Hampshire</b> b. COUNTY <b>Salem</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>166-3</b> d. STREET ADDRESS <b>28 Haigh Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Kathryn Ann Wilson</b>			4. DATE OF DEATH <b>January 18 1967</b>		5. SEX <b>Female</b>				
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 January 1957</b>		9. AGE (In years last birthday) <b>10 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Walter H. Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Gaudin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Md. 20014</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>7545</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left ventricular failure</b> DUE TO (c) <b>Sub-aortic stenosis - congenital</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b> <b>10 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <b>15 January, 1967</b> to <b>18 Jan., 1967</b> , that <b>XX</b> (we) last saw the deceased alive on <b>18 January 1967</b> , and that death occurred at <b>6:35M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Lawrence I. Bonchek, MD</b>				22b. DATE SIGNED <b>18 January 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence I. Bonchek, MD</b>			
22d. ADDRESS <b>Institutes of Health, Bethesda, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>1-21-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ELMWOOD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>METHUEN, MASS</b>		
24. FUNERAL DIRECTOR <b>W. W. Chamberlin, Co. 1400 Chapin St. D.C.</b>				25a. REC'D BY REGISTRAR <b>W. W. Chamberlin</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01099

## CERTIFICATE OF DEATH

01098

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4812 Edgely Road</u>	
3. NAME OF DECEASED (Type or print) <u>IVA MAY WINANS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 7, 1907</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Topeka, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Doeg.</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edwin O. Winans - husband</u>		Address <u>911 D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary myocardial disease</u> 422.2 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>January, 1963</u> , to <u>January 19, 1967</u> , that (1) (we) last saw the deceased alive on <u>Jan 1</u> 19 <u>67</u> , and that death occurred at <u>6:40 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Nelson G. Goodman</u> M.D.		22b. DATE SIGNED <u>1/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NELSON G. GOODMAN</u>		22d. ADDRESS <u>221 PENNSYLVANIA AVE, N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan. 20-1967</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City or town) (County) (State) <u>Washington</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>1254</u>		25a. REC'D BY REGISTRAR <u>JAN 20 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01099

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DoA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3909 Vergilia St</u>		15-1	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Kuck</u> Last <u>Winters</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/12</u>	9. AGE (In years lost birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-38-8906</u>		17. INFORMANT Address <u>Mrs Eliz. Lister Cherry Chase, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John E. Ball</u>		EXAMINER'S NAME (Type) <u>John E. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>1/27/67</u> Address (Street, city, town, or county) <u>Montgomery Co</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Grawlers Sons, Inc. - Wash. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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100 100

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint characters like 'X' and '1' are visible.]*



01101

CERTIFICATE OF DEATH

01100

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>PRINCE GEORGES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1625 Washington</i> OXON HILL CEMETERY	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <i>60425 Cedar Lane Temple Hills Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Grant</i> Middle <i>Secriest</i> Last <i>Wise</i>	4. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1967</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>79</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wide</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Secriest</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Washington Sanitarium &amp; Hospital - records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Cardiac Decomposition</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerotic Generalized</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>30 years</i> <i>30 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemia of Uremia secondary to severe pyelonephritis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <i>October 4, 1957</i> , to <i>January 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>January 17, 1967</i> , and that death occurred at <i>10:30</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Walcott W. Gibson</i>		22b. DATE SIGNED <i>January 17, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Walcott W. Gibson, M.D.</i>		22d. ADDRESS <i>4300 St. Barnabas Road Marlow Heights, Md. 20031</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1/19/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>GREENWOOD MEM. GARDENS</i>	23d. LOCATION (City or Town) _____ (County) _____ (State) <i>RICHMOND, VIRGINIA</i>
24. FUNERAL DIRECTOR <i>WILHELM FUNERAL HOME</i>		25a. REC'D BY REGISTRAR <i>JAN 20 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
4308 SUTLAND ROAD, SUTLAND, MARYLAND			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01102

CERTIFICATE OF DEATH

01101

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ROCKVILLE</u>		<u>151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>13524 GLENMILL RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First Middle Last <u>WOODS</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 18, 1895</u>		9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR 7 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit Juice Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHICAGO ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>CHARLES F WOODS</u>				14. MOTHER'S MAIDEN NAME <u>Guerney Landis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>357-09-4097</u>		17. INFORMANT <u>Son</u> Address <u>Same as Item 2.</u> <u>John P. Woods</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transitional cell carcinoma of bladder -</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bladder metastatic adenocarcinoma - 18-a</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1, 1966</u> , to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>1 Jan</u> 19 <u>67</u> , and that death occurred at <u>12:47</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>John D. Maylath</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>1 Jan 67</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. MAYLATH</u>				22d. ADDRESS <u>50 W. Edmonston Drive</u> <u>Rockville, Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 1-2-67</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Indianapolis, Indiana</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dr. Kemp notified and will approve.*

MEDICAL CERTIFICATION

MONTGOMERY COUNTY										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01103										
01102										
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13523 GEORGIA AVE., APT #204</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>758 FAIRVIEW AVE - APT #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>HARMON</u> Last <u>WOODWARD</u>					4. DATE OF DEATH Month <u>JANUARY</u> Day <u>18</u> Year <u>1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 29, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM M. HARMON</u>					14. MOTHER'S MAIDEN NAME <u>LEONA BAKER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>PAULIS N. KARMER</u>			Address <u>TAKOMA PK. MD. 758 FAIRVIEW AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>13 July, 1964</u> , to <u>18 Jan, 1967</u> , that (I) (we) last saw the deceased alive on <u>19 Jan, 1967</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Thomas P. Fogarty, M.D.</u>					22b. DATE SIGNED <u>18 Jan 67</u>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>			
22d. ADDRESS <u>1014 Univ. Blvd E. Silver Spring Md</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NORT E Cem.</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON VIRGINIA</u>				
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, Inc</u>					ADDRESS <u>SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>DATE JAN 24 1967</u>	

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## CERTIFICATE OF DEATH

01103

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>16.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>1520 CHILLUM RD</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES A. WRIGHT</u>		4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Isaac Wright</u>	
14. MOTHER'S MAIDEN NAME <u>Victoria Lombardy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Vera Wright same as #2</u> Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation.</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Uremia, po Coronary Heart Disease.</u> DUE TO (c) <u>ASC. Chronic renal disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours ±.</u> <u>&gt; 2 years.</u> <u>&gt; 1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20</u> , 19 <u>67</u> , to <u>Jan. 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 25</u> , 19 <u>67</u> , and that death occurred at <u>12:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Hugo G. Graziani, M.D.</u>		22b. DATE SIGNED <u>1/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hugo G. Graziani, M.D.</u>		22d. ADDRESS <u>10101 Georgia Ave, Silver Sp. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>1/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01105

CERTIFICATE OF DEATH

01104

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u># 4 Weycross Ct</u>	
3. NAME OF DECEASED (Type or print) <u>Barbara Joan Yodice</u> First Middle Last		4. DATE OF DEATH <u>Jan 7 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/33</u>
9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Gruenewald</u>		14. MOTHER'S MAIDEN NAME <u>Mary LAW ROTNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>101-20-2471</u>	
17. INFORMANT <u>John Yodice</u> Address <u>Husband - Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis, Liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic alcoholism</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cystic pancreatitis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 2</u> , 19 <u>67</u> , to <u>JAN 7</u> , 19 <u>67</u> , that (I) (we) lost the deceased on <u>JAN 7</u> , 19 <u>67</u> , and that death occurred at <u>9:45</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Stanley M Bialek</u> M.D.		22b. DATE SIGNED <u>Jan 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>STANLEY M BIALEK</u>		22d. ADDRESS <u>8218 Wisconsin Ave Mont. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

01105

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John M. Young</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>62</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawelllyn Young</u>		14. MOTHER'S MAIDEN NAME <u>Stella Maud. Jarr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margarette Young</u>		Address <u>as No 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Metastatic sarcomatous</u> DUE TO (c) <u>Benign bronchogenic carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/7</u> , 19 <u>67</u> , to <u>1/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 10</u> 19 <u>67</u> , and that death occurred at <u>542 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin L. Kolkin</u>		22b. DATE SIGNED <u>1/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Marvin L. Kolkin</u>		22d. ADDRESS <u>1015 Spring St, Rockville. Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memocacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville montg Md</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 13 1967</u>	

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